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INTERIM REPORT OF THE COMMISSION ON THE CONTRACTUAL RELATIONSHIPS BETWEEN THE GOVERNMENT AND DOCTORS IN THE PROVINCE OF BRITISH COLUMBIA

Mandate of the Commission

On October 5, 2000, I was appointed sole Commissioner, under the *Inquiry Act*, to inquire and report on the matters provided for in the following Terms of Reference:

1. To inquire into how the Provincial government and health authorities should enter into contractual relationships with medical practitioners to

    (a) serve the public interest, and
    (b) provide certainty and continuity in the provision of patient care.

2. To recommend

    (a) the elements that should be included in contracts to reflect the contractual relationships referred to in section 1, and
    (b) changes, if any, to Acts or regulations needed to implement the recommendations made in response to sections 1 and 2(a).

3. To submit to the Lieutenant Governor in Council an interim report by October 31, 2000, and a final report by December 15, 2000, concerning the foregoing.

Within the context of sections 12(1)(c) and 12(2) of the *Canada Health Act*, the Commission will examine the contractual relationships between the government and doctors in the Province of British Columbia. Those sections are:

> 12(1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province
>
> (c) must provide for reasonable compensation for all insured health services rendered by medical practitioners...;
>
> (2) In respect of any province in which extra-billing is not permitted, paragraph 1 (c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners ... of the province that provides
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> (a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners ... in the province;
> (b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and
> (c) that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province.

Guiding Principles

The mandate of the Commission is not to address all problems confronting our health care system, or even all problems relating to the provision of services by doctors. Rather, the Commission's role is to examine the bargaining structure for determining doctors' remuneration and to recommend changes, if any, to the contractual relationships and the existing legislation so that the public interest is better served.

The Commission has identified principles that should govern its review. The bargaining structure must:

(i) be premised on mutual respect;
(ii) ensure doctors receive reasonable compensation for the valuable services they provide to the public;
(iii) allow the government control over its expenditures on doctors' services and sufficient flexibility to respond to the changing health care needs of the public in the Province of British Columbia; and
(iv) provide certainty and continuity in the provision of patient care.

Background

The contractual relationships of the 1970's and 1980's between the government and doctors were premised on the social and economic environment of that time. Today, the government and doctors are faced with different demographics, including an aging population requiring greater use of medical services, increasing technology, changing societal values with respect to health care, and budgetary restraint. A significant portion of the government budget is the cost of doctors' services (including negotiated benefits). During the 1999/2000 fiscal year, payments made by the Ministry of Health that fell under the agreements between the government and doctors, including the value of benefits as reported by the Ministry, totalled approximately $1.8 billion. This amount is approximately 8.1% of the 1999/2000 actual expenditures for the entire province as reported in the Public Accounts.

In the last decade, the government has introduced measures aimed at controlling the rising cost of health care. Most significantly, in 1992, under legislation now known as the *Medicare Protection Act* (the *Act*), the government established a "hard cap" on the total amount of money available during any fiscal year for payment for doctors' services. This amount is defined as the "available amount"

under the *Act*. During a fiscal year, if it appears to the Medical Services Commission (MSC), the body established under the *Act* to manage the medical care system, that payments to doctors will be greater than the available amount, the MSC has the authority to pro-rate doctors' fees in order to remain within the available amount. Pro-rationing is a measure which has the effect of reducing fee value in the affected fiscal year.

The introduction of the "hard cap" and pro-rationing changed the nature of the contractual relationships between the government and doctors. Foremost, the British Columbia Medical Association (the "BCMA"), a society that for the past 100 years has represented the interests of its physician members, became more involved with the government in the management of the medical care system through a series of agreements ratified by its members during the 1990's.

In 1993, the BCMA, the government, and the MSC entered into a Master Agreement for the purpose of establishing an ongoing relationship "as partners in the health care system." The objectives of the agreement included the following:

1. To maintain and enhance the principles of Medicare;
2. To ensure a stable long term relationship between the government and the BCMA;
3. To ensure the delivery of medically required services to residents of the Province in an efficient, high quality and effective manner;
4. To ensure that doctors are appropriately compensated for providing services covered by the Medical Services Plan, or under alternative payment arrangements which are funded through the Alternative Payments Branch;
5. To ensure that the medical care system will continue to function well; and,
6. To contribute to the achievement of a mix and distribution of doctors based upon British Columbia's needs.

The Master Agreement, among other things, recognized the BCMA as the sole representative of doctors in British Columbia who practice on a fee-for-service or sessional basis, and defined the future agreement structures and procedures for their negotiation. It also created mechanisms for BCMA input into the annual budget for doctors' services and attempted to modify or attenuate the government's ability, through the MSC, to use its power to pro-rate. The Master Agreement remains in force until March 30, 2001, despite subsequent subordinate agreements between the parties.

As contemplated in the Master Agreement, the parties entered into a Working Agreement dated December 21, 1993. The Working Agreement primarily addressed economic issues, including overall fee value and doctors' benefit plans. It established a budget for doctors' services for the years 1992 through 1997. Because projected expenditures were more than the agreed budgets, the Working Agreement included a number of joint measures designed to contain the total fee-for-service payments within the available amount. Also, it provided that for years beyond 1997, the consultation measures in the Master Agreement would be employed for the establishment of the available amount.

In early 1996, the government determined that the cost of services provided by doctors would be greater than expected. Reluctantly, the BCMA agreed to renegotiate the Working Agreement.

The result of those negotiations was the 1996 Renewed Working Agreement, which expired on March 31, 1998. This agreement increased the available amounts set in the earlier agreement and placed full responsibility for budget overruns on doctors.

Upon the expiry of the 1996 Renewed Working Agreement, the parties were unable to negotiate a new agreement, despite the efforts of a mediator. As a result, the MSC issued a final and binding award on the 1998 agreement.

Although the resulting Working Agreement has never been formalized, the parties do not dispute the existence of the agreement.

In 1996/97, 1997/98 and 1998/99 fiscal years there were budget shortfalls. For the first time in the history of the parties, the MSC responded by pro-rationing doctors' fees. Doctors tolerated a relatively small degree of pro-rationing during the 1996/97 fiscal year. However, as the extent of pro-rationing became more significant, doctors responded by implementing a program of Rationed Access Days (RADs) beginning in March 1998 when there were 3 RADs. This grew to 20 RADs during the 1998/99 fiscal year.

In January 1998, doctors in some rural northern communities began to withdraw their "on call" services at the local hospitals in an effort to receive compensation for their on call schedules. Later, more doctors in additional rural areas joined in this collective action. Most actions resulted in doctors being available in clinics during the day and on call for the community during the off hours, but resigning their hospital privileges (except for "life or limb threatening emergencies"), effectively closing the small hospitals in their communities. Eventually, the dispute was resolved. However, some doctors now saw the collective withdrawal of service as a possible way to deal with their concerns.

In February 2000, the parties entered into a Framework Memorandum that created a new architecture reflecting the modern environment and the way in which doctors are remunerated. This new agreement deals with broad relationship and representation issues, a new Working Agreement addressing primarily economic issues and professional issues of fee-for-service doctors, and four subsidiary agreements concerning:

(i) sessional working relationships;
(ii) salaried doctors;
(iii) doctors who work on service contracts; and
(iv) doctors who work in rural practice.

Subsequently, two other subsidiary groups are being considered by the parties for inclusion under the Framework Memorandum:

(i) general practitioners, and
(ii) specialists.

All of the working agreements are subject to binding arbitration for the resolution of bargaining disputes. As part of the Framework Memorandum, the parties agreed to extend the Master Agreement until March 31, 2001, and the government also agreed to a fee increase of 2% effective September 1, 2000. The government agreed that the power to pro-rate doctors' fees would be suspended for services provided during the 1999/2000 and 2000/2001 fiscal years, while at the same time the BCMA agreed that it would develop, implement, and explore medically responsible cost-control measures. As well, the BCMA took responsibility for the budget overrun to a maximum of $10 million dollars, by implementing various initiatives with the agreement of the government and the MSC. The BCMA also agreed not to sponsor, support or condone withdrawals of service during the term of the extended Master Agreement and committed to work with the government to prevent such withdrawals.

Credit is to be given to the government and the BCMA for their attempts to adjust to the changing environment and reflect this in a progressive contractual relationship.

Ninety-four per cent of the doctors who voted ratified the negotiated Framework Memorandum. However, the BCMA currently has no means whereby it can require its members to abide by its agreements with the government, nor has the government any means to do so. In this context, it must be remembered that doctors are not employees of the government. As well, membership in the BCMA is voluntary, although approximately 90% of the doctors in the province belong to the BCMA.

Regrettably, despite the recently negotiated Framework Memorandum, doctors in Prince George chose to withdraw services in June 2000 to support their demands that additional resources for physician recruitment and retention be made available to their community.

The government responded to these service disruptions by providing funding to the Regional Health Authority to enter into a separate agreement with the local medical society. A similar response occurred with doctors in Williams Lake. There was apparent confusion between the roles of the Regional Health Authority and the Ministry of Health in undertaking these separate agreements.

Since then, doctors in other rural and smaller urban communities commenced or threatened service withdrawals. Those doctors have now generally resumed normal services in return for the government agreeing to a mediation process with Allan Hope, Q.C. as mediator, in an effort to resolve the outstanding issues in their communities.

More recently, doctors in Vancouver, Victoria, and New Westminster have threatened to withdraw or cutback services in their respective efforts to resolve issues they believe need critical attention at major tertiary care hospitals.

The Current Crisis

Despite the best efforts of the government and doctors to create a modern framework for their negotiated agreements, problems still exist. The problem that has brought the contractual relationship between the government and doctors to the attention of the public, and caused the establishment of this Commission, is the withdrawal of services by doctors. Growing public resentment towards both the government and doctors has developed in response to service disruptions.

Clearly, patient interests are not served when doctors withdraw their services. Nor are such withdrawals in keeping with the Framework Memorandum and general principles of law. Nonetheless, in dealing with this issue, it is necessary to consider why doctors believed they had to take such action.

The reasons are twofold. First, the withdrawal of services began as a response to the unilateral pro-rationing of their fees by the government. The withdrawal of services was seen by doctors as a way to protect their negotiated fee value.

Second, some doctors did not think that the bargaining process established under the Framework Memorandum served their interests in meeting what they perceived to be legitimate and emergent issues. Therefore, they decided to bargain their own agreements, using a collective withdrawal of service as a means of achieving their goals. These doctors were not bound by the negotiated agreements and neither the BCMA nor the government were able to persuade them to deal with their concerns under the Framework Memorandum.

The Commission believes that both the protection of fee values and concerns about the adequacy of the bargaining structure need to be satisfactorily addressed in dealing with the withdrawal of services by doctors.

Reforming the Contractual Relationships

At this stage of its review, the Commission is of the opinion that in order to address the issues raised in this report, the contractual relationships between the government and doctors must:

- allow doctors to protect their negotiated remuneration;
- acknowledge the government's need to control the cost of doctors' services;

- ensure that the bargaining structure works properly and fairly for the setting of doctors' remuneration;
- ensure that the various agencies, authorities, and persons representing the government are effectively coordinated in bargaining with doctors;
- ensure that the bargaining structure provides a mechanism to deal efficiently with legitimate emergent and/or critical issues; and
- protect the public interest in achieving a continuous and reliable supply of doctors' services, without resort to collective withdrawals of service as a bargaining tactic.

In order to complete its mandate, the Commission would like to hear from interested persons about these matters by December 1, 2000. Submissions can be sent to, and the Commission can be reached at, the office of the Commission counsel, Peter Gall, which is located at Heenan Blaikie, Suite 2200 – 1055 W. Hastings Street, Vancouver, BC V6E 2E9 phone: (604) 669-0011 fax: (604) 669-5101, email: Korbin@heenan.ca.

Judi Korbin
Commissioner